

**Texas Wesleyan University
Student Immunization Form**

Please complete and return to:
Texas Wesleyan University Health Services
1201 Wesleyan Fort Worth, Tx 76105
Phone# 817-531-4948 Fax# 817-531-7572

Name _____

Permanent Address _____

Resident Hall _____ Room# _____

Phone _____ Cell# _____

Date of Birth _____ Student's SSN# _____

Tetanus-Diphtheria Month/Year
Completed Primary Series _____
DT Booster-*within ten(10) years* _____

Measles, Mumps, and Rubella-MMR
*(2 doses of vaccine are required
for students born after 1957)*
Dose 1 *(at 12 months or after)* _____
Dose 2 _____

Polio
Completed Primary Series _____

Mantoux TB Skin Test *(Must be within
12 months prior to entering
Texas Wesleyan)* _____ Result: _____

Or Chest X-Ray _____ Result: _____

Hepatitis B *(strongly recommended)*
Dose 1 _____
Dose 2 _____
Dose 3 _____

Meningitis Vaccine *(strongly recommended)*

Emergency Contact Information:

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____